SPECIAL HEALTH CARE GUIDELINES

The purpose of this section is to provide school personnel guidance in planning special health care services and training for personnel involved in the provision of special health care services. The information provided is of a general nature and is not a substitute for medical evaluation and procedure; appropriate training of personnel; or scope-of-practice for state credentialed health service personnel who work in the public schools. Authorization for Administration of Special Health Care Services will have to be received from the physician and parents/guardian and on file with the school each school year. (Exhibit 7F and 7G)[1] Documentation of training of all delegated school personnel will also be kept in student's file.

Children with special health care needs may require health care services or treatments performed during the school day. These services should only be given by a person who has been delegated and trained in performing the health care service by a licensed health care professional. The delegated non-licensed school personnel will always perform these services under the supervision of a licensed registered nurse as stated in the Kentucky Board of Nursing Advisory Opinion Statement # 87-15, "Roles of Nurses in the Supervision and Delegation of Nursing Acts to Unlicensed Personnel",[8] and KRS 156.502 Health Service in School Setting – Designated provider – Liability Protection.

AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED PHYSICAL HEALTH CARE SERVICES

Student Name: _____Date of Birth: _____

Student Address: _____ City: _____ Zip: _____

Physical/Health condition for which procedure is to be performed _____

_____

Name of treatment or procedure _____

_____

Check one:
_____I have reviewed and approved the attached standardized procedures as written.
_____I have reviewed and approved the attached standardized procedures with my modifications noted.
_____I have attached my recommendations for standardized procedures.

Precautions, possible untoward reactions, and recommended intervention(s)

_____

_____

Time schedule and/or indication for the procedure _____

_____

The above treatment cannot be scheduled before or after school hours. _____

Treatment to be continued as above until _____(date)

Date of Authorization of Treatment _____(date)

Health Care Provider Signature: _____ Telephone: _____

Address: _____

City: _____ Zip: _____

FOR SCHOOL USE ONLY

School nurse's signature: _____ Date: _____

HEALTH PROCEDURES DAILY LOG

Student ________________________________ **Procedure Name** ____________________________

School Name ____ **School Year** _________

Authorized directions for procedure:

____

____

____

____

____

Time Procedure to be done: ____

Date	**Procedure Done?**		**Comments/Notes**	**Signature**
	Yes	**No**		

Parent/Guardian Request for Specialized Physical Health Care Services

Student Name: _____Date of Birth: _____

I request that the following specialized physical health care service(s) be administered to my child:

_____

_____

_____

(name of procedure)

This procedure(s) is necessary for my child to attend school and cannot be provided before or after school hours

I request that the treatment be administered in accordance with the Authorization for Specialized Physical Health Care. I will notify the school if the health status of my child changes, we change health care providers, or the procedure is changed or cancelled.

I agree to bring the necessary equipment and supplies, properly labeled, with directions for use in school.

The school is authorized to secure emergency medical services for my child whenever the need for such services is deemed necessary by the principal, school nurse, teacher, or other school personnel.

In consideration of this authorization, made at my request, I agree to indemnify and hold harmless the Board of Trustees and school personnel administering the treatment from any claim, liability, or damages caused or claimed as a result of the requested treatment.

I hereby give my permission for exchange of confidential information contained in the record of my child between

_____ and _____

(Licensed Health Care Provider Name) (School Nurse)

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Address) (Home Telephone)

_____ _____

(City/State) (Work Telephone)

Source: Zaiger, D.S. (2000) School Nursing Practice, An Orientation Manual, Chapter IX